OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Ronald Thomas ORAM**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 73/08(3)
DELIVERED ON:	21 August 2009
DELIVERED AT:	Brisbane
HEARING DATE(s):	11 May 2009, 17-18 August 2009
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, natural causes, initial medical assessment, response to prison health complaint, emergency access to cells

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Family:	Ms Maria Rinaudo-Lewis (instructed by ATSILS)
Queensland Health:	Mr Kevin Parrott (Crown Law)
Department of Communities:	Mr Michael Nicolson
RN Jillian Rayfield:	Ms Patricia Feeney (instructed by Sparke Helmore)

The *Coroners Act 2003* provides in s45 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various specified officials with responsibility for the justice system. These are my findings in relation to the death of Ronald Thomas ORAM. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of State Coroner.

Introduction

On 6 January 2008, Ronald Thomas ORAM was an inmate of the Capricornia Correctional Centre (CCC) at Etna Creek when he died at the age of 49. On the evening before his death, he complained of chest pain. He was seen by a nurse and treated for gastric reflux. At 11.00pm that evening he was seen asleep in his cell and snoring loudly. At the next routine check, shortly after 2.00am, he was found to be dead.

Because the incident was a "death in custody" within the terms of the Act it was reported to the State Coroner for investigation and inquest.[1]

These findings

- confirm the identity of the deceased, the time, place, circumstances and medical cause of Mr Oram's death;
- consider whether the actions or inactions of any person contributed to his death;
- examine the actions of Corrective Services staff in the hours before and after the death;
- consider whether the medical treatment afforded at to him at the Capricornia Correctional Centre was adequate and reasonable; and
- consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

The investigation

The investigation was conducted by Plain Clothes Senior Constable Justin Webb of the QPS Corrective Services Investigation Unit.

Police from Rockhampton scenes of crime, scientific and criminal investigation branches attended Mr Oram's cell at CCC in the early hours of 6 January 2008. A series of photographs of the scene was taken by a police

[1] s8(3) defines "*reportable death*" to include deaths in custody and s7(2) requires that such deaths be reported to the state corners or deputy state coroner. S27 requires an inquest be held in relation to all deaths in custody

photographer. Government Forensic Pathologist, Dr Nigel Buxton, also attended the scene to observe the body in situ.

Police interviewed all relevant CCC staff who provided statements either on the day of the death or shortly after. All other inmates in Unit S6 block, in which Mr Oram's cell was located, were interviewed in relation to the incident. One of Mr Oram's sons, also an inmate in Unit S6 block at the time, was interviewed by police and questioned whether Mr Oram had made any comments or concerns about his health.

Police seized documentation concerning Mr Oram from the CCC including log books, medical records, telephone recordings, professional management records. Recordings of intercom transmissions by Mr Oram and of phone calls made on his account were obtained.

Fingerprints of the body were taken at the Rockhampton Morgue and sent to QPS fingerprint analysts in Brisbane.

An autopsy examination on the body of Mr Oram took place on 7 January 2008. Toxicology testing took place as part of this process.

I find that the investigation into this matter was professionally and appropriately conducted in so far as it sought to establish whether any third party was involved in the wrongful death of the Mr Oram. The investigation did not however critique the quality of care given to Mr Oram when he called for medical attention some six hours before he was found dead. Nor did it to seek to explain how Mr Oram came to have Midazalam, a schedule 4 sedative, in his system when there was no record of it having been administered and nursing staff who might have given it to him, expressly denied doing so. Its presence was revealed by the autopsy process but no inquiries were made as to how the dead man came to ingest the drug.

Those matters aside, I thank Senior Constable Webb for his assistance.

The inquest

An inquest was held in Brisbane on 17 and 18 August 2009. Mr Johns was appointed as counsel to assist me. Leave to appear was granted to Mr Oram's family, the Department of Community Safety, Queensland Health and the nurse who treated Mr Oram on the evening before his death.

All of the statements, records of interview, photographs and materials gathered during the investigation were tendered at the inquest. The investigating officer Webb was called to give evidence, as were a number of witnesses to the events, the forensic pathologist who undertook the autopsy and three independent medical experts.

The evidence

I turn now to the evidence. Of course, I cannot even summarise all of the information contained in the exhibits but I consider it appropriate to record in these reasons, the evidence I believe is necessary to understand the findings I have made.

Personal Background

Mr Oram was born on 22 July 1958 in Clermont and was the oldest of seven children. An indigenous man, he was proud of his heritage and traced his roots to both the Darumbal tribe of Central Queensland and ancestors from the South Sea Islands. He grew up in Mount Morgan attending school to year 8 before leaving to commence work. This saw him working intermittently over the years in various agricultural and mining jobs. This was interspersed with stages of unemployment and four periods in custody ranging from a week to six months.

Mr Oram had been in a relationship with Delphine Richards and between them they were responsible for seven children; two being Mr Oram's children from a previous relationship and one, Thomas, being a child of the couple. This was clearly a troubled relationship and unfortunately one marred by alcoholism and violence.

Mr Oram had a love of soccer and seemingly regretted not having continued further with his education. Mr Oram is survived by his mother, Monica Oram, with whom he was very close and maintained a good relationship. The material before me indicates Mr Oram was loved and respected by his son Lee. No doubt he is missed by his mother, children, extended family and many friends.

Criminal history

Mr Oram had a criminal history dating back to 1972 which consisted of numerous motor vehicle offences committed when he was much younger; property offences, public nuisance offences and in latter years offences of violence that stemmed from domestic situations.

This was Mr Oram's fourth period of incarceration at CCC. The most substantial of these was a six month period between 25 May 2001 and 20 November 2001 served as a result of a domestic assault and wounding convictions.

On 29 October 2007 Mr Oram was charged with the unlawful wounding of his partner Ms Richards. Probably because she was the aggrieved under an extant domestic violence protection order, he was remanded in custody to re-appear at the Rockhampton Magistrates Court on 16 January 2008. He arrived at CCC on 30 October 2007.

As a prisoner on remand Mr Oram was given a high security classification (although he had been assessed as a lesser risk during previous periods of imprisonment) and placed in Unit S6 at CCC.

Medical history

Mr Oram underwent a medical assessment soon after arriving at the CCC. Although there were problems with aspects of it that I shall refer to later, Mr Oram disclosed no history of cardiac disease, and indeed it seems from all of the available evidence he was not aware that he had any heart problems. He did tell the assessing staff member he had recently been an in-patient at the Mt Morgan Hospital and as result the relevant records were obtained. Blood tests taken on arrival revealed the presence of an infection and penicillin injections were administered on 7 and 14 November.

At the time of his death, Mr Oram was not taking any medication. There is no record of him having complained of any symptoms that might be construed as heart-related prior to 5 January 2008 and there is no basis to conclude that he had experienced any such symptoms.

Chest pains

At approximately 7:50pm on 5 January 2008 Mr Oram used the intercom system in his cell to advise the master control room he was suffering "*chest pains that had been going for about half an hour"*. He also told the officer he spoke to that the pain had gone away but had now returned. As a result, Nurse Jillian Rayfield was contacted in the CCC Health Centre and told that Mr Oram had complained of chest pains. She agreed to attend secure cell block 6 to see to him.

Before she took up with the Correctional Service Officers (CSOs) who would accompany her to the cell, Nurse Rayfield obtained Mr Oram's medical file and checked the history he had given on arriving at the prison a little over two months earlier. She noted nothing that appeared relevant to such a complaint; in particular, he had disclosed no previous cardiac ailments or episodes. She did however note he had a history or alcohol abuse.

The CSO's and the nurse got to the cell shortly after 8.00pm. The nurse indicated she wanted to examine the prisoner and so one of the CSOs advised the master control so another CSO could join them in accordance with centre policy that after lock down cells only be opened if three or more CSOs were present.

On Nurse Rayfield's account, in response to her inquiry about the location and duration of his pain, Mr Oram told her that he had been "*feeling crook since just after tea tim"'* and indicated the pain was coming from his upper gastric region, or the bottom of his sternum by placing his hand in that region. He told her he had vomited in the toilet. She asked him whether he had any pain on the left side of his chest. To this Mr Oram replied "*Nah, it's not my heart miss".*

Nurse Rayfield asked whether Mr Oram felt the pain was coming from his gut to which he replied, "Y*eah I keep bringing a bit of muck up".*

By using a pulse oximeter the nurse had brought with her she established Mr Oram had 98 -100% blood oxygen saturation, his pulse was regular at 80 to 84 beats per minute and his respiration of 16 to 18 breaths per minute was within normal range. He was not clammy to touch and did not seem short of breath nor dizzy. His extremities were perfused. He did not seem distressed or agitated. Neither his blood pressure nor temperature was measured.

Nurse Rayfield suspected Mr Oram as suffering from indigestion or reflux. Accordingly she gave him two Panadol tablets and two Mylanta tablets. Nurse Rayfield expressly denied in her statement and in evidence giving Mr Oram any other drugs or medication.

Nurse Rayfield says she advised him to fill out the necessary form to see the doctor in the morning and to advise her via master control if the pain didn't settle as a result of the medication. Neither of the CSOs present mentioned the second of these comments in their police statements or the reports they produced for the departmental investigation of Mr Oram's death and only gave vague evidence of it after being asked leading questions. However another CSO, Mr Bell, claims to have heard the master control operator tell Mr Oram to advise staff if his condition didn't improve.

CSO's Leisa Crilly and Vicki Hick had been with Nurse Rayfield when she attended upon Mr Oram at about 8.00pm. They are sure that after the nurse had visited him, Mr Oram was locked in his cell alone.

Later in the evening, they again attended the cell block on two occasions to undertake a routine head count. On each occasion CSO Crilly inspected the cells on the bottom level of the two storey 30 cell block where Mr Oram was housed.

The first inspection took place at 11.00pm. Mr Oram was seen by CSO Crilly sitting on his bed with his back against the wall and his right arm folded across his stomach. She noted the rise and fall of his chest and could hear him snoring loudly.

The death is discovered

The next headcount was scheduled for 2.00am. By 2:05pm CSO Crilly had checked all of the other prisoners and was at Mr Oram's cell. Looking through the Perspex panel in the cell door, she could see he was in the same position as before, but with his right arm now on the bed. In the light of her torch, she noticed he did not seem to be breathing: there was no sign of his chest rising and falling.

CSO Crilly banged on the panel with her torch in an attempt to wake him. When that had no effect, she called to CSO Hick who by this stage was coming down from the floor above. They both called and banged on the door to no effect.

At about 2:08am CSO Crilly contacted master control and asked the operator to attempt to wake Mr Oram with the use of the intercom. When this was unsuccessful, she asked that the other night staff be directed to attend so that they could enter the cell. She believes she also spoke to Nurse Rayfield and advised her of her concerns. The other CSOs arrived at the cell and the master control opened the unlocked it. It seems the cell door was opened at about 2.13am.

CSO Crilly and CSO Brookes both felt for a pulse with negative results. Traces of vomit could be seen around Mr Oram's mouth and on his shirt. A "code blue" was then broadcast signifying there was a medical emergency. Mr Oram was moved to the floor and placed in the recovery position.

Nurse Rayfield heard the radio communications and quickly made her way to the cell with the emergency trolley. She was met on way by a CSO who took over moving the trolley so she could move more quickly, unencumbered to the cell.

Within a minute or so, Nurse Rayfield arrived and conducted an examination of Mr Oram. She noted his extremities to be cold and stiff, his pupils to be fixed and dilated, an absence of a pulse and respiration and that he was unresponsive to painful stimuli. She quickly determined that he was dead and beyond resuscitation.

Post mortem response

The cell was secured and locked at 2:27am and not disturbed until the arrival of police. A log of all events and personnel arriving and leaving the scene was recorded.

Police arrived at the scene at approximately 3:30am. The Health Services Co-ordinator for CCC was advised of the situation by Nurse Rayfield. At 4:05am Dr Wendy Christie, the on call doctor for CCC that evening, confirmed life to be extinct and signed a certificate to that effect.

At 5:15am Dr Nigel Buxton, an experienced forensic pathologist who was later to conduct the post-mortem examination, arrived to inspect the scene.

Mr Oram's son, Lee, who was accommodated in same cell block at the CCC was notified of his father's death and a support person was allowed into his cell.

Mr Oram's body was escorted to Rockhampton Hospital Morgue later in the morning.

Cause of death

An autopsy examination was carried out on 7 January 2008 by Dr Buxton.

In his report he recorded his observations of Mr Oram's body in his cell. He found that it appeared 'peaceful' and there was no evidence of violence or indeed anything to suggest the interference of a second person in the death.

Dr Buxton concluded after the post-mortem examination that:

> '*Death in this patient appears natural and can be attributed to severe coronary artery disease. There is no evidence that a second person played a physical role in this man's death, there is no evidence of bruising or trauma to the deceased.*
>
> *The degree of coronary artery disease is severe and death could have occurred at any time. The involvement of the right main coronary arteries supplying the muscle of the inferior aspect of the heart may well have lead to diaphragmatic irritation and apparent indigestion. The myocardium showed no evidence of macroscopic change to indicate that infarction had occurred when the patient first summoned help (approximately 2000 hours on the 5th of January 2008)*
>
> *In view of the degree of abnormality within the heart, I do not believe resuscitation at the moment of cardiac arrest would have been successful.*'

Histology confirmed the presence of severe calcific atherosclerosis.

Toxicology testing found paracetamol, as expected in someone who had taken two Panadol tablets a few hours before death. Of concern, however, traces of Midazolam, a short acting benzodiazepine sedative, were also found.

Dr Buxton recorded the cause of death as:

> *1(a) Coronary artery occlusion due to, or as a consequence of*
>
> *1(b) Coronary artery atheroma*

Dr Wayne Kelly, a consultant physician and the director of intensive care medicine at the Brisbane Private Hospital reviewed the autopsy report and associated material. He agreed that Mr Oram had extremely severe coronary artery stenoses. However, he opined that the proximate cause of death was more likely to be an arrhythmia – a disturbance of the heart's rhythm. He based this on the absence of an autopsy finding of an intraluminal blood clot or rupture of cholesterol plaque. He also suggested that an arrhythmia may have been precipitated by sleep apnoea (although Mr Oram had never been diagnosed with this condition and he was not overweight as are most suffers of OSA) and/or vomiting.

Dr Buxton discounted the significance of no clot being found at autopsy: he pointed out the arteries were so occluded that a thrombus of only one or two millimetres in diameter could interrupt blood flow and the arteries were so calcified the force needed to dissect them could easily have displaced such a small obstruction.

He accepted arrhythmia may have been the mechanism of death but remained of the view an occlusion was the primary cause of death.

Both doctors considered the absence of any evidence of ischemic damage to the heart muscle tissue indicated death had occurred within an hour or so of the interruption of adequate blood supply leaving insufficient time for the changes that would otherwise have been detected by histology. Opinions differ as to the time required for infarcted tissue from an ischemic event to become evident at autopsy. Most pathologists consider if a person dies within twelve hours of suffering a heart attack, evidence of it in the form of dead heart muscle tissue may not be found, even with histology. This makes it difficult or impossible to determine whether the absence of such tissue appearances in Mr Oram's heart is sufficient to exclude a conclusion that the pain he experienced "*after dinner*", some five to seven hours before his death, was heart related.

The apparent presence of the Midazolam in Mr Oram's blood was of course of concern. The nurse who might have been suspected of administering it denied doing so and her denial was supported by a number of eye witnesses. I am persuaded that even if present, the drug had no bearing on Mr Oram's death. Dr Kubler, an experienced clinical pharmacologist, said the very low concentration of the drug reported by the toxicologist means it could not have played any part in the death. While Midazolam can certainly kill in certain circumstances, death would result very soon after the drug was administered. The metabolism of it would then cease and the fatal level would be detected at autopsy. As the test indicated Mr Oram had metabolised and eliminated all but unquantifiable traces of the drug from his system, I am able to conclude it played no part in his death.

However, the unauthorised and unrecorded administration of a schedule 4 drug would still be of concern. In an effort to investigate that issue further I requested Mr Neville Bailey, the Team Leader of the Toxicology Section of Queensland Health Scientific Services, to re-examine Mr Oram's blood sample. This was done. I was advised of the findings late on the afternoon of 21 August after I had delivered my initial findings in this matter. Re-testing found no trace of Midazolam. The toxicologist advised that the possibility of changes in the sample since it was taken some 20 months previous to the second test could not be excluded. However, he also advised that a review of the results of original test done soon after Mr Oram's death did not provide a basis for finding the had any of that drug in his blood. Mr Bailey wrote:-

> *the initial laboratory report should not have included midazolam because the concentration of this drug was below the recognised laboratory guideline for reporting level and the detection was based on a single analysis.*

Contrary to the submissions made by counsel for the family after this further advice was received, this does not mean that the drug was present but should not have been reported because of reporting guidelines. It means the test results are so uncertain there is no basis for concluding the drug was in the blood tested. In those circumstances I accept the evidence of the eye witnesses that no drugs were injected into Mr Oram on the day of his death.

I accept, given the timing of death hypothesized by Dr Buxton, that Mr Oram's inability to be revived when seen by CSO's and Nurse Rayfield at around 2:15am would have been obvious. The decision not to call for an ambulance or attempt to resuscitate Mr Oram was therefore entirely reasonable.

Investigation findings

Fingerprint analysis of the sample taken from the body revealed it to be identical to fingerprints held on QPS records for Ronald Thomas Oram.

An examination of the cell by police scenes of crime and scientific officers did not reveal any signs of violence. There was nothing suggesting the involvement of another person in Mr Oram's death.

No information was obtained from the other prisoners in Unit S6 that was inconsistent with the manner of death put forward by Dr Buxton. Lee Oram's statement to police spoke of his daily contact with his father. He could not recall his father ever complaining about health problems that could be construed as cardiac related.

Findings required by s45

I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. As a result of considering all of the material contained in the exhibits, I am able to make the following findings in relation to the other aspects of the matter.

Identity of the deceased –	The deceased person was Ronald Thomas Oram
Place of death –	He died at the Capricornia Correctional Centre, Etna Creek in Queensland.
Date of death –	He died on 5 or 6 January 2008.
Circumstances and cause of death –	Mr Oram died from natural causes namely coronary artery occlusion due to, or as a consequence of, coronary artery atheroma while he was a prisoner in the Capricornia Correctional Centre.

Comments and recommendations

Section 46, insofar as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

Evidence contained in the external inspectors report commissioned by the Chief Inspector QCS indicates there were serious problems in the work practices and conditions in the Medical Services Division of the CCC at the time of Mr Oram's death. However, as there is no evidence those matters directly contributed to this death and as the Department of Community Safety and Queensland Health have apparently constructively responded to the recommendations of that report, I do not consider it necessary for me to further review those issues.

In this case, issues that warrant consideration from a prevention perspective are:-

- The adequacy of the medical assessment of Mr Oram soon after his arrival at the CCC;
- The adequacy of the nurse's response to his complaint of chest pain on the evening of his death; and
- The time taken to enter his cell and summon assistance when he was found unconscious at about 2.00am

Initial medical assessment

Mr Oram was assesed soon after arriving at the prison. Details of his recent hospitalisation were noted and the records obtained. Blood tests detected an infection that was treated. He was given vitamin supplements. His vital signs were recorded but a complete medical examination was not undertaken. It seems two questionnaires were administered. The first was more general and contained only four questions relating to medical issues. The answers recorded were internally inconsistent and of little benefit. The second was more detailed but focussed only on the subject's current medical condition. As a result, no detailed medical history was obtained.

In this case it made no difference to the outcome as Mr Oram had no history of heart problems. However in other cases it may have. Nurse Rayfield advised that before she went to see Mr Oram at 8.00pm in response to his complaint of chest pains, she checked his file. As she acknowledged, a history of cardiac disease may have prompted her to undertake a different assessment which may have led to a different diagnosis.

Since Queensland health assumed responsibility for the provision of health care to inmates of correctional centres[2] all policies have undergone or are undergoing review. The statement of the director of nursing advises that the current policy already provides for the undertaking of a full clinical examination of all prisoners on reception. The soon to be promulgated revised policy will include changes to make medical history taking more specific and it will include mandatory fields. In those circumstances I don't consider further comment by me is necessary in relation to this issue.

[2] Referred to as Offender Health Services even though it also applies to those on remand who have not been convicted.

Assessment of Mr Oram at 8.00pm

Nurse Rayfield examined Mr Oram after he had complained of chest pains. She sat him on his cell bed and sought to establish what had prompted the complaint and his current condition. The portion of her attendance on the prisoner which was tape recorded without her being aware that this was happening demonstrates that she sought to establish a rapport with the patient whom she had not previously met. I have no hesitation in accepting she was genuine in her endeavour to assist him. She is an experienced nurse and impressed me as a compassionate and caring health professional.

Nurse Rayfield observed some of his vital signs but she did not take his temperature or measure his blood pressure. She took note of his demeanour and colour and felt his skin for signs of clamminess. She did not ask open questions about the nature of his pain nor explicitly exclude symptoms that might have suggested angina. She seems to have placed weight on his concurrence with her suggestion the pain was in his gut and on his denial that it was cardiac related. She seems to have had no conscious regard to Mr Oram being in the high risk category for heart disease on account of his age, ethnicity and gender. It might reasonably be suggested that in the circumstances, chest pain should have been assumed to be cardiac related until proven otherwise.

While Nurse Rayfield's differential diagnosis of reflux pain was not at all unreasonable, it could have been confirmed or negated by her checking the effect of the antacid medication she gave him. Instead, it seems likely he was advised to contact master control if the pain persisted. This may have been unwise having regard to the well recognised trait of gratuitous compliance among Indigenous people in general and prisoners in particular.

While I have concluded that the response to Mr Oram's complaint was less than ideal, I readily accept the evidence of Dr Kelly and Dr Buxton that even were the nurse to have concluded the pain could be cardiac related, it is almost certain that no reasonable response which would have flowed from that conclusion would have prevented his death later in the evening. Dr Kelly went so far as to say even had Mr Oram been in a monitored cardiac care unit when he suffered the heart attack that killed him, it is unlikely he could have been saved.

The Offender Services director of nursing in her statement advises the management of chest pain is included in the review of policies currently being undertaken. This will include having standardised flow charts for emergency management in the equipment used to respond to such incidents. In those circumstances I don't consider any further comment by me is necessary in relation to that issue.

Delay in accessing the cell

The evidence indicates that approximately eight minutes elapsed between CSO Crilly noticing that Mr Oram was not responding, and apparently not breathing and this cell being opened and a "code blue" being called. In this

case that made no difference because Mr Oram had been dead for some time and could not have been revived even if paramedics were on the scene instantly. However, it is easy to foresee circumstances in which such a delay could cost a life.

The delay was contributed to by the need for another CSO to be present when cells are to be opened after lock down. The policy provides that two officers and the officer in charge must be present. The DCS in its submission indicates this would have happened far more quickly had the CSOs at the door of the cell complied with the policy which stipulated they should call a code blue upon noting the prisoner was not breathing.

Unfortunately this was not put to the officers when they gave evidence so we do not know their reason for waiting until they gained entry to the cell before calling the code blue. However, on reading the policy it does not appear to explicitly require such a response. Rather it requires staff to "*raise the alarm" "in the event of a medical emergency*". In this case it seems the officers waited till they could confirm Mr Oram was in fact suffering a medical emergency before they called for assistance.

Recommendation 1 – Review of code blue policy

I recommend the Department of Community Safety review its policy governing responses to medical emergencies to ensure it mandates an appropriate response as soon as an emergency may reasonably be thought to exist and take steps to ensure all staff are aware of the need to do so.

Another concern relates to the necessity for the officer in charge to be present before a cell is opened at night. It might well be the case that the safety of officers requires a certain number to be in attendance before a cell is opened, but I can see no reason why a specific office holder should be part of that number. I feel sure the Department would not expect five CSOs and a paramedic to stand outside a locked cell door watching an inmate expire her last few breaths simply because the officer in charge could not be immediately located or was delayed getting to the cell. (Indeed it seems the officer in charge did not attend in this case.)

Recommendation 2 – Review of requirement for O/C to attend

I recommend the Department of Community Safety review the policy that stipulates cell doors can not be opened at night except in the presence of the officer in charge.

I close the Inquest.

Michael Barnes
State Coroner
Brisbane

21 August 2009